

Application for Employment

At Home Senior Care Plus, LLC

Important: Answer ALL questions. Answers that are illegible or incomplete may prevent us from considering your application. **Also, DO NOT fill out this form in your browser, it will not save your completed form.**

An Equal Opportunity Employer

It is policy of At Home Senior Care Plus, LLC to provide employment opportunities without regard to race, color, religion, sex, national origin, age, handicap or veteran status.

Personal Data

Date: _____ email address: _____

First Name: _____ MI: _____ Last Name: _____

Home Address: _____

City: _____ State: _____ Zip Code _____

Home Telephone: _____ Alternate Telephone: _____

Social security # _____ Date of Birth: _____

Do you have your OWN transportation? Yes () No ()

If hired, would you be able to present evidence of your U.S citizenship or proof of your legal right to work in the United States? Yes () No ()

If hired, are you willing to submit to and pass a controlled substance test? Yes () No ()

Have you ever been convicted of criminal offense (Felony or Misdemeanor)? Yes () No ()

If yes, please describe the crime, the nature of the crime (s), when and where convicted and disposition of the case: _____

(Note: No applicant will be denied employment solely on the grounds of conviction of a criminal offense. The date of the offense, the nature of the offense, including any significant details that affect the description of the event, and the surroundings circumstances and the relevance of the offense to the position(s) applied for may, however, be considered.

Position information

Position applying for: _____ Salary Expectations: \$ _____/hour

Are you applying for? Full Time _____ Part-time: _____ Any: _____

What days are you available (circle all that is applicable) SUN MON TUE WED THUR FRI SAT

Hours you are available for work each day: _____ Have

you ever been employed by AT HOME SENIOR CARE PLUS? Yes () No ()

Employment History

(Please fill ALL employers starting with your present or most recent employer- use the back of the page if necessary)

Date: From: _____ To _____ Company/Employer: _____

Address: _____ Telephone: _____

Position held: _____ Supervisor: _____

Salary: _____ Description of Responsibilities/skills: _____

Date From: _____ To _____ Company/Employer: _____

Address: _____ Telephone: _____

Position held: _____ Supervisor: _____

Salary: _____ Description of Responsibilities/skills: _____

Date: From: _____ To _____ Company/Employer: _____

Address: _____ Telephone: _____

Position held: _____ Supervisor: _____

Salary: _____ Description of Responsibilities/skills: _____

Education

Please include any training

Date: from: _____ To _____ High school: _____

Address: _____

Telephone: _____ Did you graduate? : Yes () No () if no did you get your GED? : Yes () No ()

Higher education

Date: From: _____ To _____ School: _____

Address: _____

Telephone: _____ Major: _____

Did you graduate? : Yes () No () if yes, date completed: _____

Training

Date: from: _____ To _____ School: _____

Address: _____

Telephone: _____ Name of course: _____

Did you complete the course? : Yes () No () if yes, date completed: _____

Training

Date: From: _____ To _____ School: _____

Address: _____

Telephone: _____ Name of course: _____

Did you complete the course? : Yes () No () if yes, date completed: _____

At Home Senior Care Plus, LLC
Drug testing/ SLED background check consent
form Probationary Employees

Please initial after each statement

Pursuant to my application for employment with At Home Senior Care Plus, LLC I consent to take a drug test and have a SLED background check done as part of the company's drug free Workplace policy. _____ Initial

I understand and agree that I may be randomly tested for drugs at any time At Home Senior Care Plus, LLC so desires or deems appropriate. _____ Initial

I understand that the cost of my pre-employment tests, twenty six (\$52.00), will be deducted from my first paycheck. _____ Initial

I consent to the lease of my test results received from the testing laboratory and SLED to management officials at At Home Senior Care Plus, LLC and understand that these results will be held in confidence by all parties involved. _____ Initial

I understand that if I tested positive for presence of illegal drugs, or drugs not prescribe to me by a licensed Doctor, I will have the opportunity to discuss those results with the management of At Home Senior Care Plus, LLC for the purpose proving a reasonable explanation regarding my positive drug test. _____ initial

I further understand that if my test remains positive for the presence of illegal or non-prescribed drugs, I will be terminated from further employment with At Home Senior Care Plus, LLC. _____ initial

By signing my name, I fully understand terms of At Home Senior Care Plus, LLC drug testing and random drug testing policy.

Applicant's Name: (Print) _____ Date: _____

Applicant's Signature: _____ Date of Birth: _____

Home Telephone: _____ Alternate Telephone: _____

POST-OFFER MEDICAL QUESTIONNAIRE

Employee Name: _____

Social Security Number: _____

Date of Birth: ____/____/____

Gender: Male Female

Height: _____

Weight: _____

NOTICE TO OFFEREEES: In compliance with the Americans with Disabilities Act of 2008 (ADA), you have received a conditional offer of employment. This medical history statement is required of all offerees. The answers to the medical history statement and any medical examination will be kept confidential and in separate files in compliance with the ADA requirements. The job offer, which you have received, is conditioned upon satisfactory completion and review of this medical questionnaire and any required medical examination or follow up.

GINA DISCLOSURE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

EMPLOYEE AFFIRMATION: I herewith affirm that the employer has made me an offer of employment, conditioned on, among other things, the satisfactory completion of this questionnaire. The purpose of this inquiry is as follows: (1) to determine whether I currently have the physical qualifications necessary to perform the essential functions of the job that has been offered; (2) to determine what accommodations, if any, may be necessary for me to

PERSONAL HEALTH HISTORY

1. Have you ever had or been treated for any of the following conditions or diseases?

Herniated Disc YES NO

Knee injury YES NO

Surgical removal of disc or spinal fusion YES NO

Back injury YES NO

Hernia or rupture YES NO

Diseased process of the spine YES NO

Neck injury, pain, or problems YES NO

Chest Pain YES NO

Shoulder injury YES NO

Arthritis or rheumatism YES NO

Arm/hand injury YES NO

Wrist problems YES NO
(including Carpal Tunnel Syndrome)

Repetitive motion disorders YES NO

Broken bones YES NO

Ankylosis YES NO
Immobility of any major, weight-bearing joints (ankles, knees, hips)

Tendonitis YES NO

Head injury YES NO

Amputations YES NO

Epilepsy, fainting spells, or dizziness YES NO

2. Have you sought treatment from a healthcare provider for any of the above injuries and/or medical conditions?

YES NO

3. Are you capable of performing the essential duties of this job function? YES NO

4. Do you have any injury or condition that requires a reasonable accommodation in order for you to be able to perform the essential duties of this job position? YES NO

If yes, what accommodations do you need to perform the job? _____

5. How much weight can you lift comfortably unassisted?

< 15 lbs 15-25 lbs 25-39 lbs ≥ 40 lbs

6. Has a healthcare provider placed any limitation on your ability to sit, stand, push, pull, or lift?

YES NO

If yes, what are the limitations?

7. Has a healthcare provider limited the amount of weight you can lift? YES NO

If yes, list the weight limitation and the date that your healthcare provider issued you the limitation:

8. Are you taking any prescribed drugs that interfere with you safely performing your job? YES NO

If yes, list the medications: _____

9. Have you ever been hurt on the job or filed a Workers' Compensation claim? YES NO

If yes:

Date(s): _____

Treating physician(s): _____

Body part(s): _____

My signature certifies that all facts and representations made by me are true, accurate and made willingly and intentionally.

Signature of Employee Printed Name Date

Company Representative Date